Philadelphia University Faculty of Nursing



Approval date: Issue: 1

Department: Nursing Academic year 2021\2022

Course Syllabus

Bachelor

Credit hours: 3

Course information

Course#	Course title				P	rerequisite
0910432	Gerontological Nursing (Clinical)				Wit	h 0910431
Course type			Class ti	me	Room #	
□ University Requirement □ Faculty Requirement		Wed		Field		
Major Requirement		\Box Elective	□ Compulsory	8:15-2:00		

Instructor Information

Name	Office No.	Phone No.	Office Hours	E-mail	
Dr. Mayada A. Daibes	4505	2116	Sun, Mon, Wed 1:00- 2:00	mdaibes@philadelphia.edu.jo	
Instructor: MS. Sara Saad	4505	2116		saadsarah353@gmail.com	

Course Delivery Method

Course Delivery Method					
☐ Physical ☐ Online ☐ Blended					
	Learning Model				
Precentage	Synchronous	Asynchronous	Physical		
			100%		

Course Description

This course equips the nursing students with the required skills to perform his/her role in meeting the physiologic, psychosocial, and spiritual needs of the elderly. It provides nursing student with evidence-based clinical expertise that helps them, as gerontological nurses, to address the complexities of meeting the holistic needs of the elderly population with competence in hospitals and community based settings.

Course Learning Outcomes

Number	Outcomes	Corresponding Program outcomes
Knowledge		
K1	Recognize the normal physiologic, psychosocial, and spiritual changes of the older adult due to aging	KP1
Skills		
S1	Utilize the nursing process and critical thinking skills to develop a plan of care for common physiologic, psychosocial, and spiritual problems of the older adult.	SP2
S2	Demonstrate effective communication skills in providing safe and quality care for older adults.	SP1
Competencie	S	
C1	Utilize beneficial cost effective nursing care plans to provide safe, high quality nursing services to elderly population, employing the appropriate communication skills and technologies.	CP2+CP3

Learning Resources

Course textbook	Eliopoulos, C. (2018). <i>Gerontological nursing</i> . 9 th Ed. Lippincott Williams & Wilkins.	
Supporting References		
Supporting websites		
Teaching Environment	⊠Classroom (Lab) □ laboratory □Learning platform ⊠	
	Other (Field Practice)	

Meetings and subjects timetable

Week	Торіс	Learning Methods	Task s	Learning Material
1.	Introduction			
	School Vision, Mission and Safety			
	Measurements.			
	Schedule and syllabus	Lab Lecture		
2	Safety precautions (falling down,			
2.	medications considerations, normal			
	changes)			
	Field work	Collaborative		
	Objectives:	learning,		
	- Check Safety measures	demonstration,		
3.	- Assess risk of Falling	role play,		
	- Assess Lightening	Problem based		
	- Assess Room decoration	learning		
1	Field work	Collaborative		
4.	- Discuss Medications and check	learning,		

	Med Stock.	domonstration
	Med Stock.	demonstration,
		role play,
		Problem based
		learning
	Field work	Collaborative
	Objectives:	learning,
5.	 Assess and discuss sleeping 	demonstration,
	conditions	role play,
		Problem based
		learning
	Field work	Collaborative
	Objectives:	learning,
6.	 Discuss Normal changes 	demonstration,
0.		role play,
		Problem based
		learning
	Field work	Collaborative
	Objectives:	learning,
7.	 Discuss Abnormal changes 	demonstration,
/•	(cardiovascular (lab results, vital	role play,
	signs, respiratory system)	Problem based
		learning
	Field work	Collaborative
	Objectives:	learning,
8.	- Discuss Abnormal changes	demonstration,
ð.	(digestive and oral cavity)	role play,
		Problem based
		learning
	Field work (Open day)	Collaborative
		learning,
9.		demonstration,
9.		role play,
		Problem based
		learning
	Field work	Collaborative
	Objectives:	learning,
10	- Discuss Abnormal changes	demonstration,
10.	(sensory)	role play,
	· · · · · · · · · · · · · · · · · · ·	Problem based
		learning
	Field work	Collaborative
	Objectives:	learning,
	- Discuss Abnormal changes	demonstration,
11.	(Integumentary changes)	role play,
		Problem based
		learning
	Field work	Collaborative
	Objectives:	learning,
	- Discuss Abnormal changes	demonstration,
12.	(Musculuskeletal)	role play,
	(1) LUGUIUDACIUUI)	Problem based
		learning

	second case study at labs)	learning, Problem based learning	
14	Final Exam (Oral presentations of the	Problem based	
14.	second case study at labs)	learning	
15.	Final Exam (Written)		

* includes: Lecture, flipped Class, project- based learning, problem solving based learning, collaborative learning

Course Contributing to Learner Skill Development

Using Technology
Use databases effectively to support evidence-based knowledge and practice
Communication skills
Self-Reflection, Friendliness, Confidence, Empathy, Respect, Responsiveness, Morality
Application of concepts learnt
Leadership skills, and lifelong learning skills

Assessment Methods and Grade Distribution

Assessment Methods	Grade Weight	Assessment Time (Week No.)	Link to Course Outcomes
Mid Term Exam	30%	$2^{\text{nd}}-8^{\text{th}}$	K1, S1, C1
- Professionalism (Pre-mid 5 points)			
<u>App. 3</u>			
- Physical Examination (Pre-mid 5			
Points) <u>App. 6</u>			
- Health Education (Pre-mid 10			
Points) <u>App. 2</u>			
- One case study (pre-mid 10 points)			
<u>App. 5</u>			
Various Assessments *	30%	2^{nd} -13 th	K1, S1, C1
- Professionalism (post-mid 5			, ,
points) App. 3			
- One case study (Post-Mid 10			
Points) <u>App. 5</u>			
- Health Education (Post-Mid 10			
points) <u>App. 2</u>			
- Geriatric Activity (5 points) <u>App.</u>			
	40.07	a ath	
Final Exam	40%	14 th	K1, S1, C1
- Final Written Exam (20 points)			
 Nursing care plan (20 Points) <u>App.</u> 			
<u> </u>	100%		
10(a)	100 /0		

* includes: quiz, in class and out of class assignment, presentations, reports, videotaped assignment, group or individual projects.

Number	Learning Outcomes	Learning Method*	Assessment Method**			
	Knowledge					
K1	Recognize the normal physiologic,	Lectures,	Reports			
	psychosocial, and spiritual changes of the older	Problem	Exam			
	adult due to aging	Based				
		Learning,				
		Group				
		discussions,				
		Case				
		studies,				
		seminars,				
		open day				
	Skills					
S1	Utilize the nursing process and critical thinking	Case	Reports			
	skills to develop a plan of care for common	studies,	Exam			
	physiologic, psychosocial, and spiritual	Nursing				
	problems of the older adult.	care plan,				
		Health				
~ •		education				
S2	Demonstrate effective communication skills in	Case	Reports,			
	providing safe and quality care for older adults.	studies,	Open day			
		Nursing	evaluation			
		care plan,				
		Health				
		education				
<u>C1</u>	Competencies	Due 1-1	D			
C1	Utilize beneficial cost effective nursing care	Problem	Reports			
	plans to provide safe, high quality nursing	Based				
	services to elderly population, employing the	Learning, Health				
	appropriate communication skills and					
	technologies.	education,				
		case studies				

Alignment of Course Outcomes with Learning and Assessment Methods

* includes: Lecture, flipped Class, project- based learning , problem solving based learning, collaborative learning

** includes: quiz, in class and out of class assignment, presentations, reports, videotaped assignment, group or individual projects.

Course Polices

Policy	Policy Requirements		
Passing Grade	The minimum passing grade for the course is (50%) and the minimum final		
	mark recorded on transcript is (35%).		
Missing Exams	 Missing an exam without a valid excuse will result in a zero grade to be assigned to the exam or assessment. A Student who misses an exam or scheduled assessment, for a legitimate reason, must submit an official written excuse within a week from the an exam or assessment due date. A student who has an excuse for missing a final exam should submit 		

	the excuse to the dean within three days of the missed exam date.					
Attendance	The student is not allowed to be absent more than (15%) of the total hours					
	prescribed for the course, which equates to six lectures days (M, W) and					
	seven lectures (S,T,R). If the student misses more than (15%) of the total					
	hours prescribed for the course without a satisfactory excuse accepted by the					
	dean of the faculty, s/he will be prohibited from taking the final exam and					
	the grade in that course is considered (zero), but if the absence is due to					
	illness or a compulsive excuse accepted by the dean of the college, then					
	withdrawal grade will be recorded.					
Academic	Philadelphia University pays special attention to the issue of academic					
Honesty	integrity, and the penalties stipulated in the university's instructions are					
	applied to those who are proven to have committed an act that violates					
	academic integrity, such as: cheating, plagiarism (academic theft), collusion,					
	and violating intellectual property rights.					

Program Learning Outcomes to be assessed in this Course

Number	Learning Outcome	Course Title	Assessment Method	Target Performance level
SP2	Enable students to apply the gained nursing skills, including the physiological, psychological and social integrity of health care recipients	Gerontology nursing (Clinical)	Demonstration test	Passing rate of 90%
CP2	Apply global health standards, values, and ethics in providing nursing care for individuals, families, and groups.	Gerontology nursing (Clinical)	JNC Licensing Exam, Employers' satisfaction survey	70% of students passing 90% satisfaction rate
CP3	Apply the gained soft skills with peers, individuals, families, groups, and health care team	Gerontology nursing (Clinical)	Employers' satisfaction survey	90% satisfaction rate

Description of Program Learning Outcome Assessment Method

Number	Detailed Description of Assessment
SP2	Independent Demo Exam held at end of 4 th year level. 90% of students completed Training course shall pass.
CP2-3	JNC Board Exam (70% of students Pass), Employer Satisfaction Survey (>90% satisfaction rate)

To be disseminated later***

Semester Assessment Schedule 2021/2022 1 st semester																
Week	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	9 th	10 th	11 th	12 th	13 th	14 th	15 th	16 th
Professionalism	Pre- mid	Pre- mid	Pre- mid	Pre- mid	Pre- mid	Pre- mid	Pre- mid	Post- mid (تسليم علامات للمنسق)	Post- mid	Post- mid	Post- mid	Post- mid (اخر اسبوع في الميدان)	x	x	x	تسليم العلامات للمنسق
Health Education	x	Х	x	6 طلاب Pre- Mid (in groups of 2)	6 طلاب Pre- Mid (in groups of 2)	6 طلاب Pre- Mid (in groups of 2)	6 طلاب Pre- Mid (in groups of 2)	Pre- Mid (تسليم علامات للمنسق	6 Post- mid (in groups of 2)	6 Post- mid (in groups of 2)	6 Post- mid (in groups of 2)	6 Post- mid (in groups of 2)	x	X	X	
Case Study	x	x	x	(bed- side)	(bed- side)	(bed- side)	(bed- side)	تسليم العلامات للمنسق	On paper	On paper	On paper	On paper	Discuss ion of case studies	Discus sion of case studie s	x	
Physical Examination (bed-side)	x	x	х	P/E	P/E	P/E	P/E	تسليم علامات								

Nsg Care Plan							تسليم الطالب		
Geriatric					Open				
Activities					day				

Appendix 1 Nursing care plan

Student name: Student's ID:	
I. <u>Demographic data (1 mark):</u>	
Client's Name	Age
SexRoom/Bed No	Address
Education	Occupation
Marital Status:	_Single/ married / widower / divorced
Family Type: Nuclear / Joint .	Source of History data
Date of assessment	

CHIEF COMPLAINT (if in hospital sitting)

PRESETNT ILLNESS (2 mark):

PAST MEDICAL HISTORY (1 mark):

PAST SURGICAL HISTORY (1 mark):

FAMILY HISTORY(0.25):

LAST DIAGNOSTIC PROCEDURES (1 MARK):

Name of procedure	Date	Result	Interpretation

LAST LABORATROY PROCEDURES (1 MARK):

Name of the test	Date	Result	Normal Value	Interpretation

CURRENT MEDICATIONS (2 MARKS):

SYSTEMS REVIEW

A. Physical assessment (0.25 Mark): Walk, Independently: Needs assistance by Person: Walker: Wheel chair: Complete bed rest

B. Review of System: (Assessment of the following) (1 MARK):

System	Symptoms	Ubnormal findings
Visual		
Auditory		
Cardiovascular		
Cardiovasculai		
Pulmonary		
-		
Gastro-intestinal		

Genitourinary	
Musculoskeletal	
Neurologic system	
Extremities	
XX7 * 1 / 1	
Weight change	

C. Ability to perform ADLS (1 mark):

Care (Ability	Independen		Totally	Remarks
For Self-Care)	•	dependen		
Items		•	-	
1. Eating				
2. Dressing				
3.Combing				
4. Morning care (toileting)				
5. Bathing				
6. Elimination (urine/stool)				

D. Diet of the elderly client (1 mark):

a) Ordinary diet

b) special diet

Nutritional Habits and Problems

Habits / Problems	Specify\Quantify	Nursing Interventions
1. Anemia		
2. Anorexia		
3. Denture Problem		
4. Digestive problems		
5. Smoking		
6. Tea / Coffee		
7. Other issues		

E. Special Complaints (1 mark):

Complaints	Problem	Nursing Intervention
1. Inability to care for own self		
2. Insomnia		
3. Headache		
4. General Pain		
5. Arthritis		

6. Others	

F. Psychological assessment (1 mark):

Complaints	Problem	Nursing Intervention
1- Sense of purpose in life		
2. Not able to adjust to life changes and new events		
3. Always live in the past		
4. Do you forget recent events?		
5. Does it seem that no one understands you?		
6. Do you feel weak all over much of the time?		
7. Do you feel lonely?		
8. Is your sleep disturbed?		
9. Do you have depressed mood most of the time?		

G. Social assessment (0.25 mark):

Ability to discuss present current event: Able /confused /Low power of concentration
 Special hobbies and interest: Walking / reading / Playing cards / watching TV / other (Specify______)

H. Social support system (0.25 mark):

Visit of the family members and friends to the elderly in the home

Family	Yes / No
Friends	Yes / No
Relatives	Yes / No

Who lives with you ? _______ Have you talked to any friends or relatives on phone ? Yes / No (how many times per week) Are you satisfied by seeing your friends or relatives as often as you want ? Is there someone who would care for you ? Yes / No

I. Mental status Assessment (1 mark):

1. General Appearance (Please check Where applies)

Posture	Slouched	Rigid	
Dress	Inappropriate for	or place weather	
Grooming	Meticulous	Un-kept	poor hygiene

2. Non-verbal communication:

Angry facial expression	
Restless	
Agitated	
Lack of eye contact	
3. General behavior:	
Tense Resentful / Hos	tile
Unwilling to participate in care / uncoc	operative
4. Mood:	
Tearful Elated	_ sudden mood changes
Flat affect	
5. Speech / language:	
Slow Monotonous tone	Rapid nonstop
Discuss in appropriate topic	Flight of ideas
Incoherent garbled	disorganized
6. Orientation (level of awareness)	
Unaware of time:	
Unaware of place:	
7. State of consciousness:	
Slow movements and delayed response t	o stimuli
Respond only to vigorous stimuli	
No response to stimuli	
8. Memory:	
No recall of recent memory	

No recall of past events _

9. Information or knowledge level:
Distorted perception of cause of the problem
Lack of understanding of reason for treatment
Poor comprehension of required skill
Denial of the problem or need for treatment

Summary of abnormal findings in subjective and objective data (1 mark):

<u>Nursing care plan (3 marks)</u>: mention at least 3 nursing diagnosis and prioritize those diagnoses

Nursing	
diagnosis (1)	
Goal(s) and objectives	
objectives	

Nursing	
interventions	
	•••••••••••••••••••••••••••••••••••••••
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	••••••
Evaluation	
Nursing	
diagnosis (2)	
Goal(s) and	
objectives	
o o joo u , o o	
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Nursing	
inuising	
interventions	•••••••••••••••••••••••••••••••••••••••
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Evaluation	
L'uluulon	
Nursing	
diagnosis (3)	
Goal(s) and	
Goal(s) and objectives	
Goal(s) and objectives	
Goal(s) and objectives	
Goal(s) and objectives	
objectives	

	••••••
	••••••
Evaluation	

Appendix 2

Health Education Rubric form

Clinical Area:	Date:
Student Name:	Student N.O
Subject Title:	•••••

Evaluator Name:.....

No	Items	1	2	3	4	5
1	General professional appearance					
2	Relevant & applicable to gerontological nursing					
3	Introduction/objectives					
4	Organization of content					
5	Accurate knowledge (Pathophysiological, nursing, background)					
6	Accurate, clear & Appropriate vocabulary/ terminology					
7	Utilization of research pertinent to the topic					
8	Appropriate to level of audience					
9	Initiate & control the discussion					
10	Use of audiovisual aids					
11	Summary & conclusion					
12	Evaluate the health education process					
13	Time control					
14	Written material is well prepared					
15	Motivate participation and brain storming					
Total]	points (out of 75 points)					

1.Poor 2. Fair 3. Good 4. Very good 5. Excellent

Student's mark out of 20%: -----

Instructor's Signature: -----

Appendix 3 Professionalism Rubric Form

Student Name:

ID No.:

	1	2	3	4	5
1. Relationship with:	1	I			I
a.Clients					
b. Colleague					
c.Supervisors					
d. Working personnel					
2. Professional Behaviors:					
a.uniform(clean, neat, &tidy)					
b. Adhere to code of ethics					
c.Exhibit Caring Behavior.					
d. Present on time.					
e. Excused/ unexcused					
3. Personality:					
a. Self-Motivated.					
b. Polite & patient.					
c. Assertive					
4. Leadership Ability:					
a. Ability to lead the group.					
b. Ability to control the group					
c. Ability to make decisions					
d. Ability to manage with different situations.					
5. Self-directed.					
6. Nursing process application.					
7. Maintains professional conduct.					
8. Exhibit critical thinking& creativity.					
9. Demonstrates self-awareness.					
10. Demonstrate teaching-learning skills.					
Total (out of 105 points)					

Student's mark out of 5 points:

Instructor's Signature and Date

Appendix 4

Geriatric Activities Rubric Form

Student Name: Event subject:	ID No.: Event Date:					
Item	Poor (1)	Fair (2)	Good(3)	V.good(4)	Excellent (5)	
Targetive						
Relevant						
Innovative & Creative						
Organized						
Satisfaction of audience				-	1	
- Venue						
- Organization						
- Logistics (food, etc.)						
- Performance of students						
Total points (out of 40 points)						

Student's mark out of 5%:-----

Instructor's Name and Signature:-----

Appendix 5

Case study presentation Rubric Form

Student Name:	
Topic title:	

Student's ID:..... Date:....

Item	Poor (1)	Fair (2)	Good (3)	V.good (4)	Excellent (5)
Assessment (normal					
changes, abnormal					
changes)					
Pathophysiology					
Pharmacological and non-					
pharmacologic					
management					
Nursing Process					
Summary and conclusion					
Research evidence					
Clear, organized,					
understandable					
Delivered on time					
Total points out of 40					
points					

Student's mark out of 10%:.....

Instructor's Name and signature:.....

Appendix 6 Physical examination Rubric Form

Student Name:..... Student's ID.:....

Date:....

Client's Age:..... Client's Medical condition:.....

Item	Poor (1)	Fair (2)	Good (3)	V.good (4)	Excellent (5)
1. General appearance:					
- Affect/behaviour/anxiety					
- Level of hygiene					
- Body position					
- Patient mobility					
- Speech pattern and articulation					
-summarizes normalities and					
abnormalities					
2. Skin, hair, and nails:					
- Inspect for lesions, bruising, and rashes					
- Palpate skin for temperature, moisture,					
and texture					
- Inspect for pressure areas.					
- Inspect skin for edema.					
- Inspect scalp for lesions and hair and					
scalp for presence of lice and/or nits.					
- Inspect nails for consistency, colour, and					
capillary refill.					
-summarizes normalities and					
abnormalities					
3. Head and neck:		-1		-	T
- Inspect eyes for drainage.					
- Inspect eyes for pupillary reaction to					
light.					
- Inspect mouth, tongue, and teeth for					
moisture, colour, dentures.					
-Inspect for facial symmetry.					
-summarizes normalities and					
abnormalities					
4. Chest:					
Inspect:					-
-Expansion/retraction of chest wall/work					
of breathing and/or accessory muscle use					
-Jugular distension					
Auscultate:	1	-		-	1
-For breath sounds anteriorly and					
posteriorly					
-Apices and bases for any adventitious					

sounds					
-For symmetrical lung expansion	+				
-summarizes normalities and					
abnormalities					
5. Abdomen:	<u> </u>		<u> </u>		
Inspect:					
Abdomen for distension,	T				
Auscultate:					
Bowel sounds (RLQ)					
Palpate:	<u> </u>		<u> </u>		
-Four quadrants for pain and					
bladder/bowel distension (light palpation					
only)					
-Check urine output for frequency, colour,	-				
odor.					
-Determine frequency and type of bowel					
movements.					
-summarizes normalities and	1				
abnormalities					
6. Extremities:	1			1	
Inspect:					
-Arms and legs for pain, deformity,					
edema, pressure areas, bruises					
-Compare bilaterally					
Palpate:				·	
-Radial pulses					
-Pedal pulses: dorsalis pedis and posterior					
tibial					
- capillary refill (hands and feet)					
-Assess handgrip strength and equality.					
-Assess dorsiflex and plantarflex feet					
against resistance (note strength and					
equality).					
-Check skin integrity and pressure areas.					
-summarizes normalities and					
abnormalities					
7. Back area (turn patient to side or ask to	sit up or	lean forw	ard):	1	
-Inspect back and spine.					
-summarizes normalities and					
abnormalities	<u> </u>				
8. Tubes, drains, dressings, IVs, oxygen a	nds:				
-Inspect for drainage, position, and					
function.					
-Assess wounds for unusual drainage.	<u> </u>				
- assess oxygen aids for positioning,					
efficacy.	<u> </u>				
-summarizes normalities and abnormalities					
	1				
9. Mobility: -Check if full or partial weight-bearing.					
-Check if full of partial weight-beating.	<u> </u>				

-Determine gait/balance.			
-Determine need for and use of assistive			
devices.			
-summarizes normalities and			
abnormalities			
Total points (out of 245 points)			

Student's mark out of 5%: -----

Instructor's Name and Signature: -----